

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

88002

89007

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>MARY</b>	Middle <b>CATHERINE</b>	Last <b>BENNETT</b>	2a. DATE OF DEATH Month <b>JUNE</b>	Doy <b>27</b>	Year <b>1968</b>	2b. HOUR <b>5:20 P.M.</b>	
3. SEX		4. RACE	5. DATE OF BIRTH <b>2/7/1885</b>			6. AGE (In years lost birthday) <b>83</b> YRS.			
<b>FEMALE</b>		<b>NEGRO</b>				IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ST. MARYS</b>			
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARYS NURSING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>		13b. COUNTY <b>ST. MARYS</b>	13c. CITY OR TOWN <b>RIDGE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>RURAL</b>		
14. FATHER'S NAME First <b>DANIEL</b>		Middle <b>LEE</b>	Last	15. MOTHER'S MAIDEN NAME First <b>ZORA</b>			Middle	Last <b>TARLETON</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. <b>218 24 0639A</b>			17. INFORMANT <b>MR. EDWARD BENNETT - RIDGE, MARYLAND</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of urinary bladder</b> APPROXIMATE INTERVAL 188 X BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1810									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 26, 1968</b> , to <b>June 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J.C. Roa M.D.</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>June 27, 1968</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/30/68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. PETER CLAVER CEM.</b>			23d. LOCATION (City or Town) <b>RIDGE, MARYLAND</b>			(County) (State)
24. FUNERAL DIRECTOR <i>John M. Welch</i>		ADDRESS <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>			25a. REC'D BY REGISTRAR <b>JUL - 2 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Juge</i>	

00320

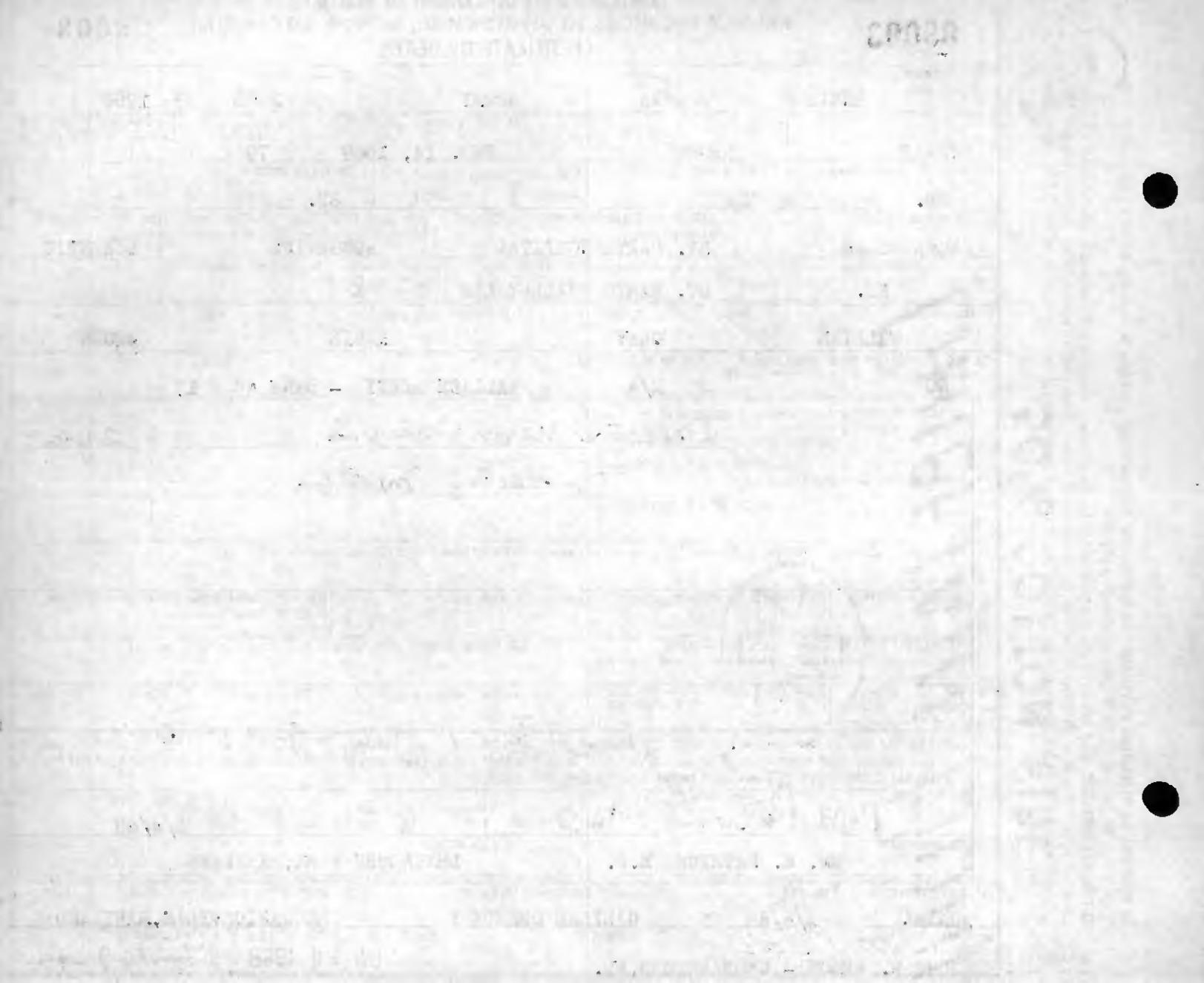
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Roger L. and 2  
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Roger L. and 2  
 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First <b>ANNIE</b>	Middle <b>JOANNA</b>	Last <b>BERRY</b>	2a. DATE OF DEATH Month <b>JUNE</b>	Day <b>3</b>	Year <b>1968</b>	2b. HOUR M.	
3. SEX <b>FEMALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>FEB. 14, 1889</b>			6. AGE (In years last birthday) <b>79</b> YRS.			
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARYS</b>				
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARYS HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ST. MARYS</b>		13c. CITY OR TOWN <b>VALLEY LEE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>WILLIAM</b>			Middle <b>GRAY</b>	Last	15. MOTHER'S MAIDEN NAME First <b>ANNIE</b>			Middle	Last <b>BROWN</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>WALLACE BERRY - SAME AS # 13</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic Nephroclerosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. <i>Diabetes Mellitus</i> . 2509										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2409										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (his hospital) attended the deceased from <i>June 1, 1968</i> , to <i>June 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 3, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>W.H. Patrick MD</i>		22c. DEGREE <b>MD</b>		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>6/4/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>WM. H. PATRICK M.D.</b>			LEXINGTON PARK, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/6/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>GALILEE CEMETERY</b>			23d. LOCATION (City or Town) <b>MECHANICSVILLE, MARYLAND</b>			
24. FUNERAL DIRECTOR <i>John M. Welch</i> <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		ADDRESS			25a. REC'D BY REGISTRAR DATE <b>JUN 10 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

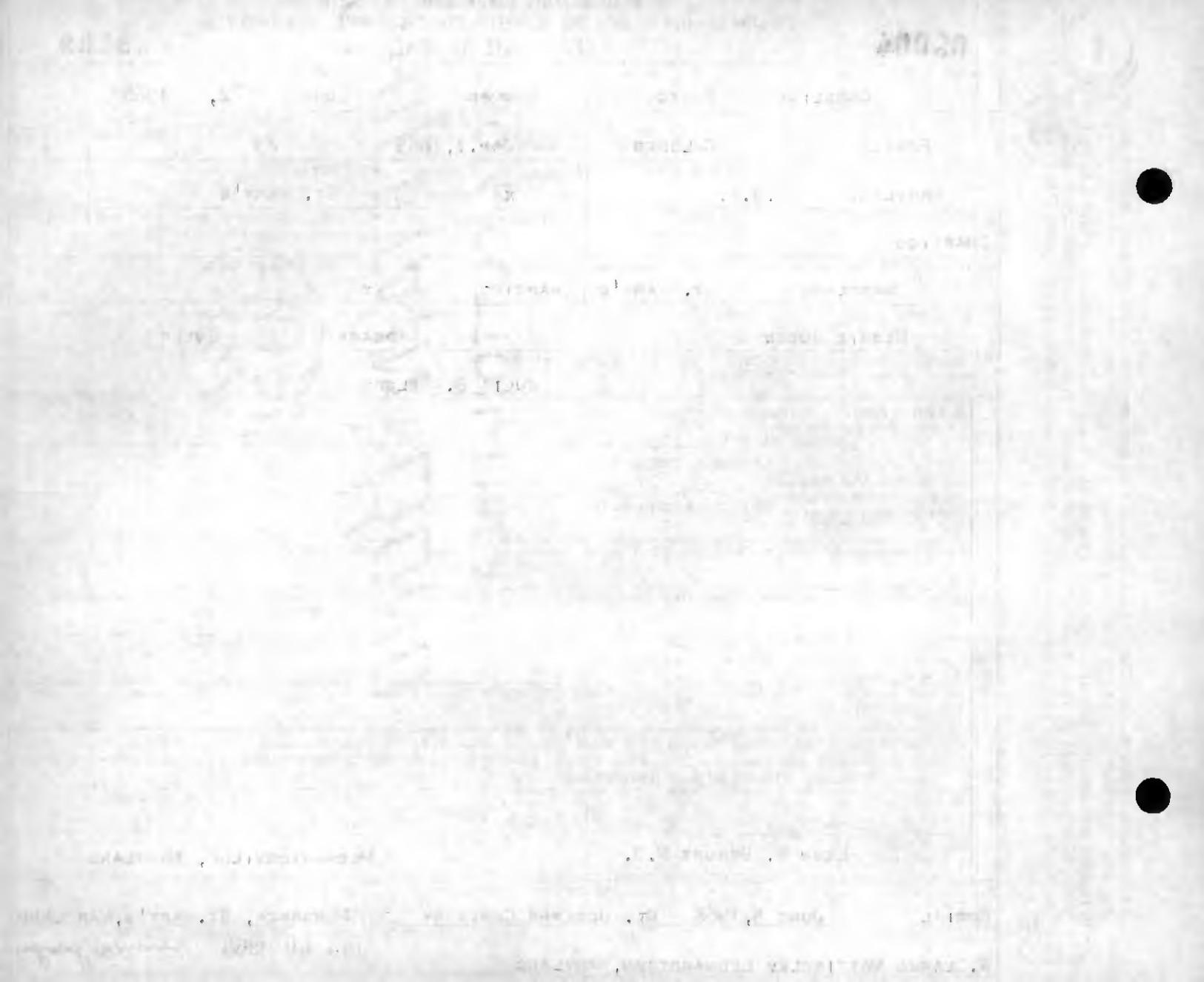
CERTIFICATE OF DEATH

**I**  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. (If you do not have a carbon paper, you should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.)

1. DECEASED-NAME (Type or print)		First <b>CAROLINE</b>	Middle <b>REBECCA</b>	Last <b>BOWMAN</b>	2a. DATE OF DEATH Month <b>JUNE</b>	Day <b>2, 1968</b>	2b. HOUR <b>M</b>
3. SEX <b>FEMALE</b>		4. RACE <b>COLORED</b>		5. DATE OF BIRTH <b>JAN. 1, 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b>	
10. CITY OR TOWN OF DEATH <b>CHAPTICO</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>CHAPTICO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First <b>HESSIE QUEEN</b>		Middle <b></b>	Last <b></b>	15. MOTHER'S MAIDEN NAME First <b>MARGARET</b>		Middle <b></b>	Last <b>QUEEN</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
<b>4129</b>				<b>JULIA B. NELSON</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure, etc.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b> 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19, 1959</b> , to <b>May 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Leon W. Berube</b>		DEGREE <b>LEON W. BERUBE M.D.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>1968</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		MECHANICSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 5, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. JOSEPH'S CEMETERY</b>		23d. LOCATION (City or Town) <b>MORGANZA, ST. MARY'S, MARYLAND</b>		(County) (State)
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 10 1968</b>	25b. REGISTRAR'S SIGNATURE <b>James Juge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <b>JOHN</b>	Middle <b>BROOKS</b>	Last	2a. DATE OF DEATH Month <b>JUNE</b>	Day <b>5</b>	Year <b>1968</b>	2b. HOUR <b>M</b>							
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		S. DATE OF BIRTH <b>FEB. 15. 1885</b>	6. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b>		MIN. <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ST. MARY'S</b>										
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMING</b>		12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CHARLES ✓</b>		13c. CITY OR TOWN <b>CHARLES ✓ BENEDICT</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>LEN</b>									
14. FATHER'S NAME First <b>XXXXXX</b>		Middle <b>WEBSTER</b>	Last <b>BROOKS</b>	15. MOTHER'S MAIDEN NAME First <b>LENA</b>		Middle <b>DACE</b>		Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>216-18-2803</b>		17. INFORMANT <b>MRS EUGENE L. BLAND</b>		Address <b>BENEDICT, MARYLAND</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								<b>Kerebrovascular Thrombosis</b> <b>10 days</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic cv disease</b>															
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION <b>4/22/1</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hypostatic pneumonia</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>J. Roy Guyther</i>		22c. DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-6-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>J. Roy GUYHER M.D.</b>		22e. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>EBEZENER CEMETERY</b>		23d. LOCATION (City or Town) <b>G. EAT MILLS, ST. MARY'S, MARYLAND</b>		(County) <b>St. Mary's</b>		(State) <b>MARYLAND</b>					
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>Glenda J. Jones</b>		25b. REGISTRAR'S SIGNATURE <b>Glenda J. Jones</b>									
DATE <b>JUN 10 1968</b>															

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Year	2b. HOUR 8:30A
Male	Negro		Butler	June 9,	1968	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	Negro	June 9, 1968	YRS.	MONTHS	DAYS	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	Md.		
Maryland	United States		St. Mary's			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
Leonardtown	St. Mary's Hospital			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland	St. Mary's	Lexington Pk.	None	General Delivery		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
William Clement	x	Butler, Jr.		Patricia	Zanell	Walker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address			
No		Mother	General Delivery, Lexington Park, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  7690 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.				Pneumaturt 3 hours 6 mo ??		
(b) DUE TO, OR AS A CONSEQUENCE OF Dr competent Cervix						
(c) DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1968</u> , to <u>July 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED	
Ernest Rehm					1968	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS					
Ernest Rehm, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town)	(County)	(State)	
Burial	6-10-1968	St. Aloysius	Leonardtown	St. Mary's Md.		
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
W. Clarke Mettingley	Leonardtown, Md.		Charles J. Hayes			
81-16444		DATE JUN 13 1968				

1980

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

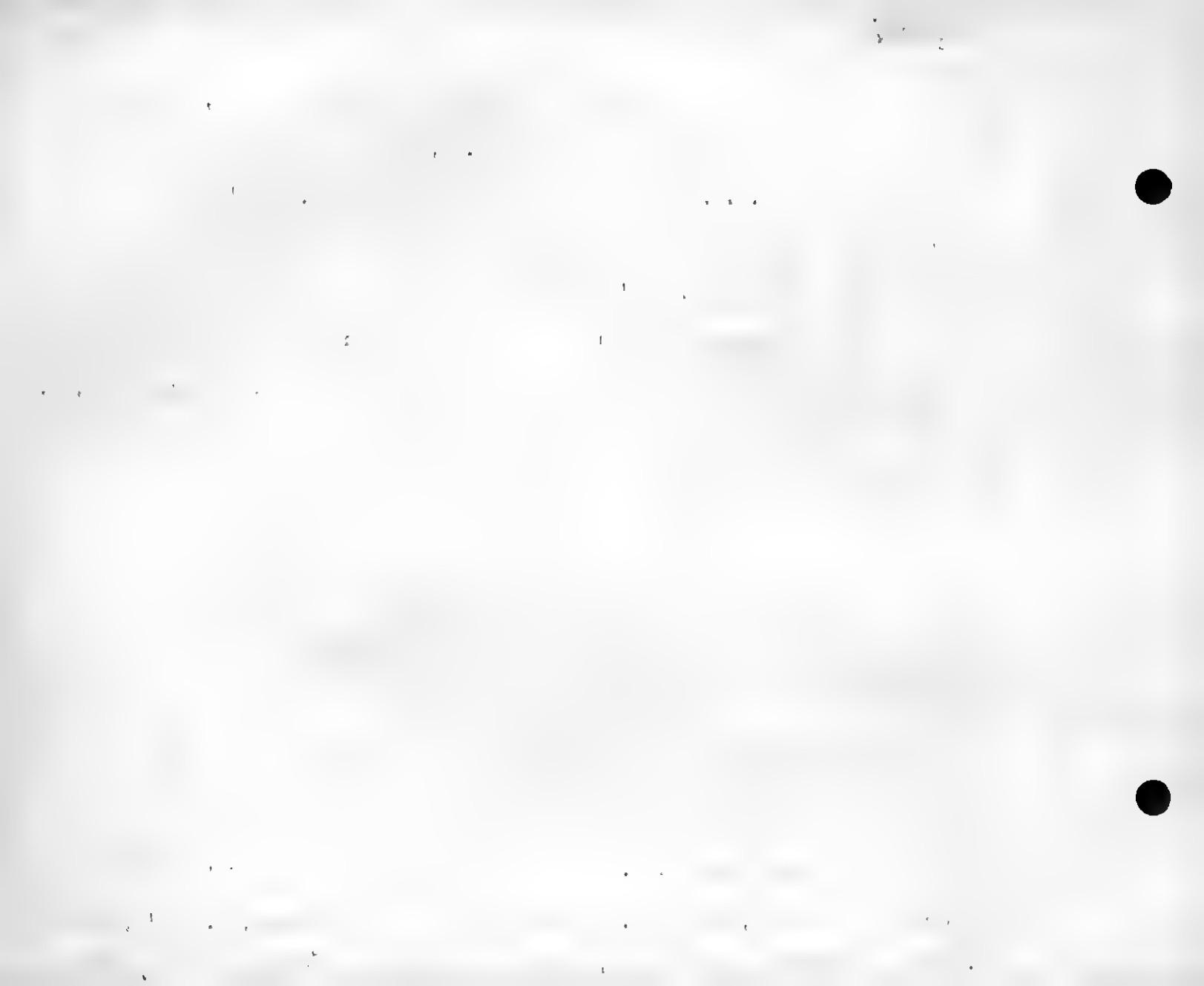
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death.  
**Page 4 may be retained by the hospital or attending physician.**

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1. DECEASED-NAME (Type or print)	First <b>JOHN</b>	Middle <b>LEONARD</b>	Last <b>CHASE</b>	2a. DATE OF DEATH Month <b>JUNE</b> Day <b>29,</b> Year <b>1968</b>	2b. HOUR <b>M</b>
3. SEX <b>MALE</b>	4. RACE <b>NEGRO</b>	S. DATE OF BIRTH <b>Nov. 18, 1965</b>	6. AGE (In years last birthday) <b>2</b> YRS.	IF UNDER 1 YEAR MONTHS    DAYS    HOURS    MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ST. MARY'S</b>		
10. CITY OR TOWN OF DEATH <b>OAKVILLE</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN <b>OAKVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER	
14. FATHER'S NAME First <b>JOHN</b>	Middle <b>LEONARD</b>	Last <b>BANKING</b>	15. MOTHER'S MAIDEN NAME First <b>FLORENCE XRM</b>	Middle <b>CHASE</b>	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <b>FLORENCE CHASE OAKVILLE, MECHANICSVILLE, MD.</b>	Address		
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>7/1/67</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Since birth</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7/5/44</b>					
19a. DATE OF OPERATION <b>7/5/44</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. <b>19</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>White</b>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Leon Berube</i>	DEGREE <b>LEON BERUBE M.D.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>MECHANICSVILLE, MARYLAND</b>
22d. PHYSICIAN'S NAME (Type) <b>LEON BERUBE M. D.</b>	22e. ADDRESS				
23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. JOSEPH'S</b>	23d. LOCATION (City or Town) <b>MORGANZA, ST. MARY'S, MARYLAND</b>	(County) <b>MARYLAND</b>	(State) <b>MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JULY 2, 1968</b>	23e. ADDRESS	25a. REC'D BY REGISTRAR <b>CHARLES JUDGE</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>	ADDRESS <b>LEONARDTOWN, MARYLAND</b>	DAY	DATE <b>JULY - 5 1968</b>		

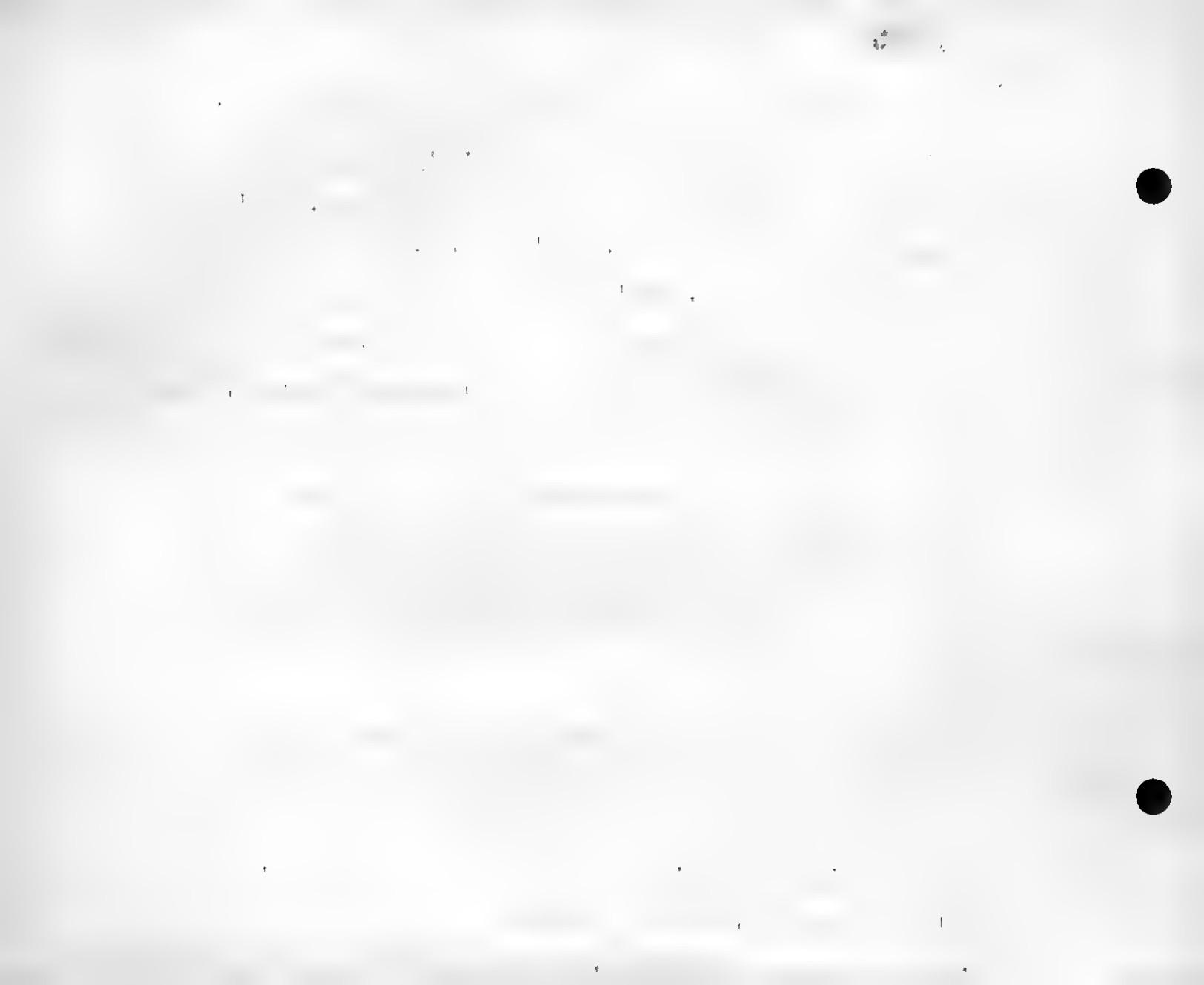


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**PAGE 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First <b>AUSTIN</b>	Middle <b>JOHN</b>	Last <b>CULLEN</b>	2a. DATE OF DEATH JUNE 8, 1968	2b. HOUR M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		S. DATE OF BIRTH <b>Nov. 25, 1886</b>	6. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>ENGLAND</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ST. MARY'S</b>			
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>McPARKLAND</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>		13c. CITY OR TOWN <b>COMPTON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>COMPTON, MARYLAND</b>		
14. FATHER'S NAME First <b>JOHN</b>		Middle <b>CULLEN</b>	Last <b>.</b>	15. MOTHER'S MAIDEN NAME First <b>MARY</b>	Middle <b>XMAS</b>	Last <b>McPARKLAND</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO <b>213-01-3564</b>		17. INFORMANT <b>CATHERINE CULLEN</b>		Address <b>COMPTON, MARYLAND</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4120</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Particulars</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral vascular accident</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>443x</b>								
19a. DATE OF OPERATION <b>19b. DATE OF OPERATION</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJRY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJRY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJRY OCCURRED <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJRY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCAT ON Street or R.F.D. No		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1968</b> , to <b>June 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 8, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.								
22b. SIGNATURE <b>S. Laurel, M.D.</b>		DEGREE <b>MD</b>	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>LEONARDTOWN, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>FORT LINCOLN</b>		23d. LOCATION (City or Town) <b>LEONARDTOWN, MARYLAND</b>		(County) (State)
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINOLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>Charles George</b>		25b. REGISTRAR'S SIGNATURE <b>Charles George</b>		
VR A15 (4) 30M REV. 1/68				DATE JUN 12 1968				



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
				WILLIAM	PATRICK	DOUGLAS	JUNE	11	1968	M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		NEGRO		Nov. 3, 1906			61 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND		U.S.A.				ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
LEONARDTOWN		ST. MARY'S HOSPITAL									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		HALF		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND		ST. MARY'S		CHARLOTTE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		PATRICK		DOUGLAS			CHARLOTTE		BUTLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW II		17. INFORMANT		Address					
		214-18-8329		ELBERT H. DOUGLAS		MECHANICSVILLE, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>486 X</u> <u>7 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Atherosclerotic CV dis. &amp; Hemiplegia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1968</u> , to <u>June 1968</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>J. Roy Guyther, M.D.</u>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS		22e. DATE SIGNED <u>6-13-68</u>					
22d. PHYSICIAN'S NAME (Type)						MECHANICSVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)					
BURIAL		6/15/68		EBENEZER CEMETERY		NEW MARKET, ST. MARY'S, MARYLAND					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STAR		25b. REG STAR'S SIGNATURE					
W. CLARKE MATTINGLEY		LEONARDTOWN, MARYLAND									
30M REV 3/64		DATE JUN 17 1968		<u>Charles J. Guyther</u>							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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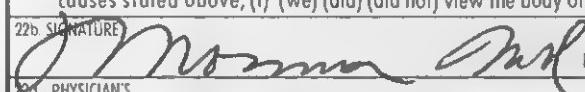
1. DECEASED NAME (Type or print)		First <b>LEROY</b>	Middle <b>BENNELLE</b>	Last <b>GODDARD</b>	2a DATE OF DEATH JUNE Month 21, Day 1968	2b. HOUR M	
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>SEPT. 19, 1919</b>		6. AGE (In years at birthday) <b>48</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b>		
10. CITY OR TOWN OF DEATH <b>ST. MARY'S CITY</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN <b>ST. MARY'S CITY</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME <b>JAMES ALEXANDER GODDARD</b>		Middle <b>ALEXANDER</b>	Last <b>GODDARD</b>	15. MOTHER'S MAIDEN NAME First <b>ETHEL</b>	Middle <b></b>	Last <b>MCKAY</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>216-14-6785</b>		17. INFORMANT <b>MRS ETHEL M. GODDARD</b>	Address <b>ST. MARY'S CITY, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4109</b>		Coronary Thrombosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b>		DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arterosclerosis					<b>10 years</b>
(c)		DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from July 1958, to June 21, 1968, that (I) (we) last saw the deceased alive on Oct 20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>WILLIAM H. PATRICK M. D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>6-21-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM H. PATRICK M. D.</b>		22e. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 23, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity</b>	23d. LOCATION (City or Town) <b>ST. MARY'S CITY</b>		(County) <b>Md</b>	(State)
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 26 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles George</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

J5016

1 DECEASED NAME (Type or print)	First <b>ELIZABETH</b>	Middle <b>PAULINE</b>	Last <b>HOLT</b>	2a DATE OF DEATH Month <b>JUNE</b>	Year <b>1968</b>	2b HOUR <b>M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>COLORED</b>	5 DATE OF BIRTH <b>DEC. 5, 1918</b>	6. AGE (In years last birthday) <b>49</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b>	IF UNDER 24 MRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>ST. MARY'S</b>			
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER		
14 FATHER'S NAME First <b>SYDNEY</b>	Middle <b>WOOLAND</b>	Last <b>THOMAS</b>	15. MOTHER'S MAIDEN NAME First <b>ALICE</b>	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO <b>213-22-1058</b>	17. INFORMANT <b>WILLIAM FRANCIS HOLT</b>	Address <b>CHARLOTTE HALL, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>509</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>		
(b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes mellitus</b>				years <b>many</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>19 Oct</b> , 19 <b>58</b> , to <b>May</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19 Apr</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		22c. DATE SIGNED <b>6/5/68</b>	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>DAVID MOSSMAN M.D.</b>		22e. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 6, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>EBENEZER CEMETERY</b>	23d. LOCATION (City or Town) <b>CHARLOTTE HALL, MARYLAND</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 7 1968</b>	25b. REGISTRAR'S SIGNATURE 		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print)	First <b>MARY</b>	Middle <b>CATHERINE</b>	Last <b>JENIFER</b>	2a. DATE OF DEATH Month <b>JUNE</b>	Day <b>29</b>	Year <b>1968</b>	2b. HOUR <b>M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>COLORED</b>	5. DATE OF BIRTH <b>SEPT. 24, 1890</b>		6. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>ST. MARY'S</b>				
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN <b>CHARLOTTE HALL</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
14. FATHER'S NAME First <b>WILLIAM</b>	Middle <b>HENRY</b>	Last <b>SHORTER</b>	15. MOTHER'S MAIDEN NAME First <b>ELBIE</b>	Middle <b>JANE</b>	Last <b>BROWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <b>ADELE HOLLY</b>	Address <b>MECHANICSVILLE, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4129</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>bronchopneumonia</b>			DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral Thrombosis</b>				
DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic cv disease</b>			DUE TO, OR AS A CONSEQUENCE OF <b>Diabetes mellitus</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>None</b>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>At home farm street, factory, office building, etc.</b>	21d. LOCATION Street or R.F.D. No. City or Town County State <b>None</b>			
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 19, 68</b> , to <b>Jan. 19, 68</b> , that (I) (we) last saw the deceased alive on <b>Jan. 19, 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death <b>Roy Gylther</b>							
22b. SIGNATURE <b>Roy Gylther</b>		DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>6-10-68</b>	
22d. PHYS. CHIN'S NAME (Type) <b>J. Roy Gylther, M.D.</b>		22e. ADDRESS <b>MECHANICSVILLE, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 13, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>EBENEZER</b>	23d. LOCATION (City or Town) (County) (State) <b>NEW MARKET ST. MARY'S MD.</b>			
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, Md.</b>		25a. RECD BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
				DATE <b>JUN 13 1968</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print)		First <b>ELVA</b>	Middle <b>MABLE</b>	Last <b>KEOUGH</b>	2a. DATE OF DEATH Month <b>JUNE</b>	Day <b>26</b>	Year <b>1968</b>	2b. HOUR <b>M</b>							
3. SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>2/4/1888</b>		6. AGE (In years last birthday) <b>80 YRS</b>		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS DAYS <b>0</b>		HOURS <b>0</b>		MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARYS</b>									
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARYS HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>WASH. D.C.</b>		13b. COUNTY <b>✓</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3525 NICHOLS AVE. S.E.</b>									
14. FATHER'S NAME First <b>GEORGE</b>		Middle <b>R.</b>	Last <b>KENDRICK</b>	15. MOTHER'S MAIDEN NAME First <b>ALICE</b>		Middle <b>DEAN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown <b>NO</b>		16b. SOCIAL SECURITY NO <b>578 10 4750A</b>		17. INFORMANT <b>MARTIN R. KEOUGH</b>		Address <b>RIDGE, MARYLAND</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial Failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>									
4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i>				15 years.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>June</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June</u> , 19 <u>65</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ernest D. Rehm</i>		22c. DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/27/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>ERNEST REHM M.D.</b>		22e. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/29/68</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City or Town) <b>WASHINGTON, D.C.</b>		(County)		(State)					
24. FUNERAL DIRECTOR <i>John M. Welch</i> JOHN M. WELCH - LEONARDTOWN, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 28 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
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1. DECEASED-NAME (Type or print)		First <b>EDWARD</b>	Middle <b>NEWTON</b>	Last <b>LEE</b>	2d. DATE OF DEATH Month <b>JUNE</b>	Year <b>6, 1968</b>	2b. HOUR <b>M</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUG. 29, 1898</b>		6. AGE (in years last birthday) <b>69</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b>	
10 CITY OR TOWN OF DEATH <b>LEONARDTOWN,</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SHIPPER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARY'S LAUREL GROVE</b>		13c. CITY OR TOWN <b>LAUREL GROVE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>JOHN</b>		Middle <b>K.</b>	Last <b>LEE</b>	15. MOTHER'S MAIDEN NAME First <b>MINNIE</b>		Middle <b>SHIPLEY</b>	Last <b></b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>218 32 2374</b>		17. INFORMANT <b>MYRTLE M. LEE LAUREL GROVE, MARYLAND</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 h</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>46</i>							
MEDICAL CERTIFICATION <i>X</i>	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <b>6/6/57</b> , to <b>6/6/68</b> , that (I) (we) last saw the deceased alive on <b>6/6/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>David Moggman</i>		DEGREE <b>DAVID MOGGMAN M. D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>6/8/68</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>					
23a. BURIAL, CREMATION, BONEVA, (Specify)		23b. DATE <b>JUNE 9, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>MT. ZION CEMETERY</b>		23d. LOCATION (City or Town) <b>LAUREL GROVE, ST. MARY'S, MD.</b>		
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. RECD BY REGISTRAR <b>JUN 12 1968</b>	25b. REC STRR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

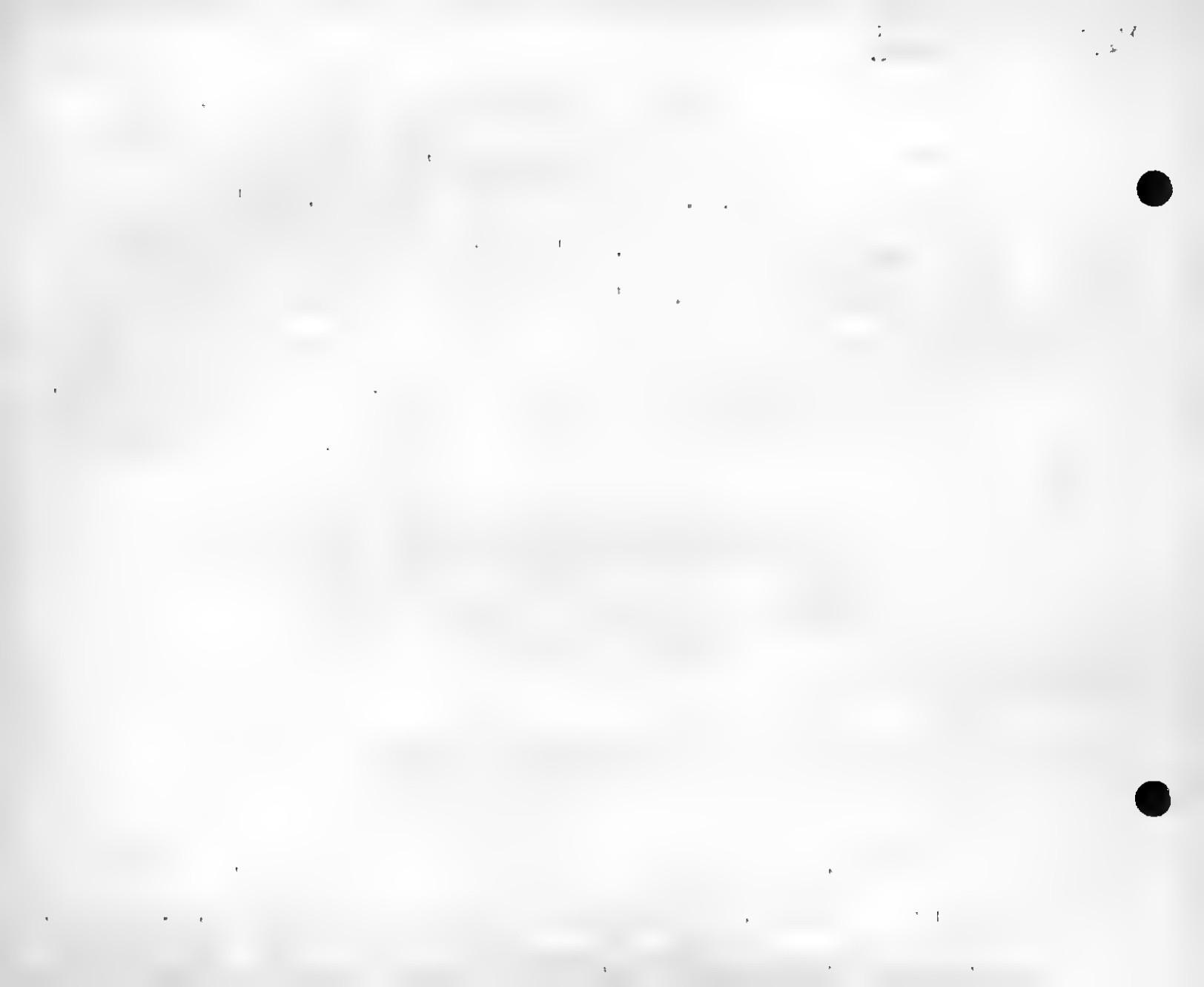
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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 2 hours after death.

1 DECEASED NAME (Type or print)		First <b>ANDREW</b>	Middle <b>JOHNSON</b>	Last <b>MATTINGLY</b>	2a. DATE OF DEATH Month <b>JUNE</b>	Day <b>8</b>	Year <b>1968</b>	2b. HOUR <b>M</b>		
3. SEX <b>MALE</b>		4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>JULY 14, 1878</b>			6. AGE (in years last birthday) <b>89</b> YRS.				
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ST. MARY'S</b>				
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARY'S HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ST. MARY'S</b>	13c. CITY OR TOWN <b>LEONARDTOWN</b>			13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14 FATHER'S NAME First <b>JAMES</b>		Middle <b>H.</b>	Last <b>MATTINGLEY</b>	15 MOTHER'S MAIDEN NAME First <b>ANN SOPHIA ABELL</b>			Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO <b>215-56-7502T</b>			17 INFORMANT <b>MARGUERITE M. BOND</b>			Address <b>LEONARDTOWN, Md.</b>		
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5740</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Massive gastro-intestinal hemorrhage						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO, OR AS A CONSEQUENCE OF Cholelithiasis & cholelithiasis										
(c) DUE TO, OR AS A CONSEQUENCE OF concomitant disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <b>6. 3. 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>abdominal aortic bypass</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>6. 1. 68</b> , 19 <b>68</b> , to <b>6. 8. 68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6. 8. 68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>A. Samadi</i>		DEGREE <b>MD</b>	ATTENDING PHYS	<input checked="" type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED <b>6. 9. 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. SAMADI</b>		22e ADDRESS			LEONARDTOWN, MARYLAND					
23a. BURIAL CREMATION, BURNING (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>OUR LADY'S CHAPEL</b>			23d. LOCATION (City or Town) <b>MEDLEY'S NECK, ST. MARY'S, MD.</b>		(County) <b>ST. MARY'S</b>	(State) <b>MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR DATE <b>JUN 12 1968</b>			25b. REGISTRAR'S SIGNATURE <i>James George</i>		

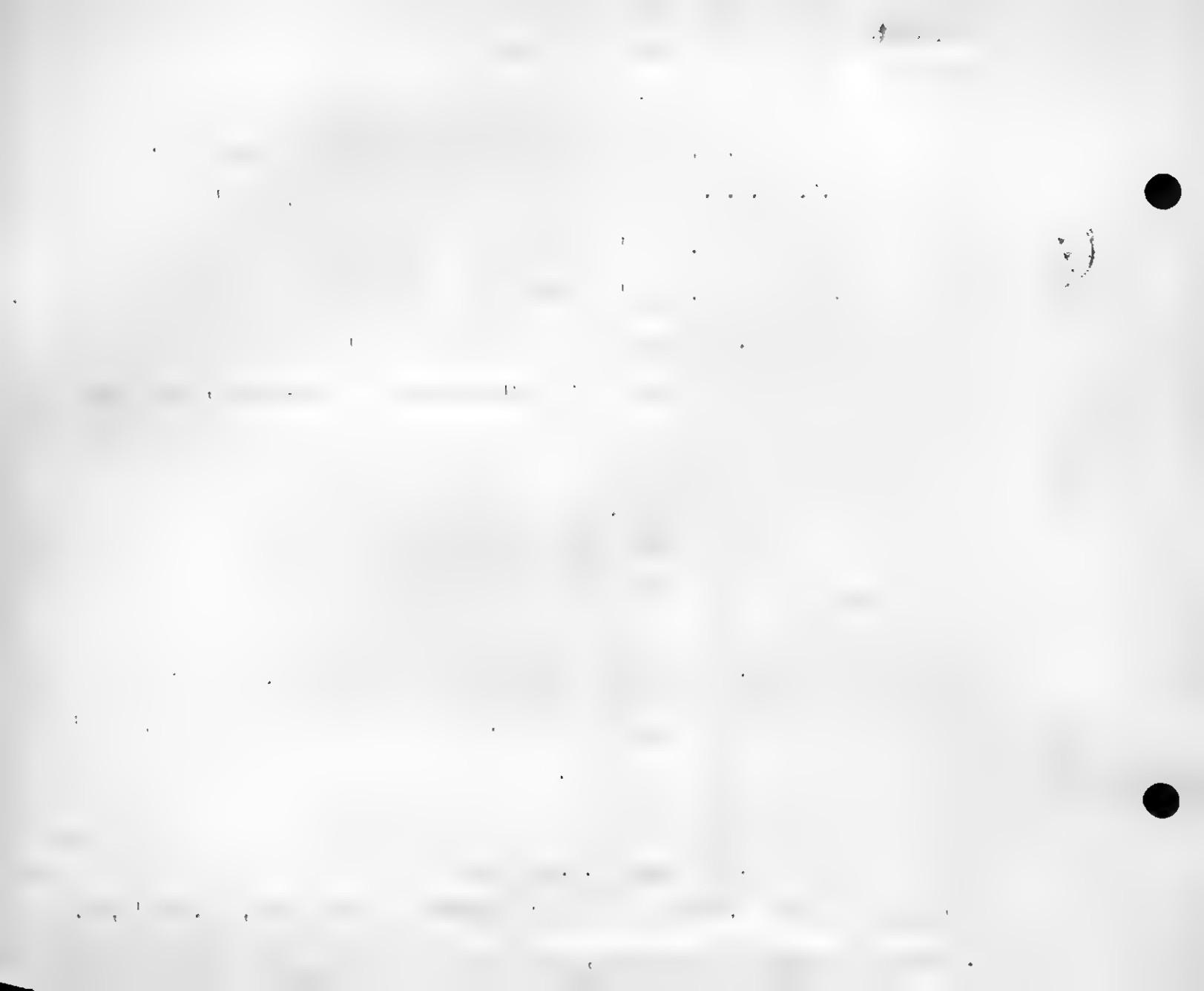


~~FOR STATE  
HEALTH DEPT.~~

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month		2b. HOUR		
		<b>FREDERICK GREENLAW SETTLE</b>			<b>JUNE 8 1968</b>		9:00P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
<b>MALE</b>		<b>WHITE</b>		<b>2/12/1897</b>		<b>71 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARYS</b>			
10. CITY OR TOWN OF DEATH <b>LEONARDTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. MARYS HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRERED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CIVIL SER.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>		13b. COUNTY <b>ST. MARYS</b>		13c. CITY OR TOWN <b>MECHANICS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RURAL RT.2</b>	
14. FATHER'S NAME First <b>FREDERICK</b>		Middle <b>GREENLAW</b>		Last <b>SETTLE</b>		15. MOTHER'S MAIDEN NAME First <b>MARTHA</b>		Middle <b>HAYNES</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217 52 7600T</b>		17. INFORMANT <b>MRS. GRETRUDE SETTLE - SAME AS # 13</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Hypostatic pneumonia</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO, OR AS A CONSEQUENCE OF <b>Heart failure Arteriosclerotic heart disease</b>							
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200 Gangrene of the right leg</b>									
19a. DATE OF OPERATION <b>June 1 1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene of the right leg</b>		20a. AUTOPSY? <b>NO</b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-3-68</b> , to <b>6-9-1968</b> , that (I) (we) last saw the deceased alive on <b>6-9-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>K. Samadi</b>		22c. DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/10/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>A. SAMADI M.D.</b>		22e. ADDRESS <b>LEONARDTOWN, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/12/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>CEDAR HILL GEM.</b>		23d. LOCATION (City or Town) <b>WASHINGTON, D.C.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>John M. Welch - LEONARDTOWN, MD.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Juge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Juge</b>			
				DATE <b>JUN 12 1968</b>					

2078

37020

~~FOR STATE  
HEALTH DEPT.~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19023

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First <b>PAULINE</b>	Middle <b>POST</b>	Last <b>TERER</b>	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 19 M	2b. HOUR 2d HOUR 1:25 PM	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday) <b>52 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>	IF HOURS <b>0</b>	MIN	
Female	White	8/10/1915						
7a. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARY'S</b>		
10. CITY OR TOWN OF DEATH <b>Lexington Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>303 Town Creek Drive</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13c. CITY OR TOWN <b>St. Mary's Lexington Pkys</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>303 Town Creek Drive</b>		
14. FATHER'S NAME <b>BERT</b>		Middle <b>WADE</b>	Last <b>POST</b>	15. MOTHER'S MAIDEN NAME <b>CARRIE</b>		Last <b>ROBINSON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>220 38 4038</b>		17. INFORMANT <b>CARL LEE TETER</b>		ADDRESS <b>SAME AS #13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4129</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>#221</b> Bronchial asthma								
19a. MEDICAL CERTIFICATION <b>1</b>		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>Parson City Cemetery</b>		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles S. Springate</b>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>June 17, 1968</b>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/20/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>PARSON CITY CEMETERY</b>		23d. LOCATION (City or Town) <b>PARSONS</b>		(County) <b>WEST VIRGINIA</b> (State)
24. FUNERAL DIRECTOR <b>John M. Welch</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
JOHN M. WELCH - LEONARDTOWN, MD.								

2023